Cooperation Between Departments of Health and Welfare

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IN 1952 the Joint Committee on Medical Care of the American Public Health and Public Welfare Associations posed the thesis that the interests and practices of public health and public welfare were bringing the agencies concerned closer together(*1*). This was not a new thesis but a restatement that was especially timely in the light of the Social Security Act amendments of 1950(*2, 3*). These amendments made possible federally matched direct payments to the providers of medical care for certain needy persons and established the Federal-State program of aid to the permanently and totally disabled.

During the past few years, through a field survey in 8 States and 10 local areas, the APWA and the APHA have sought to determine what cooperative activities are conducted in some official health and welfare departments.

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Method of the Study

The States and localities selected for study were among those in which we might expect to find an optimum potential for close working relationships between the departments. These were:

California: Alameda County, city and county of San Francisco, San Mateo County; Maryland: Carroll County; Massachusetts: city of Quincy; New Jersey: city of Newark and Essex County; New York: Ulster County; Oregon: city of Portland and Multnomah County; Washington: city of Seattle and King County; Wisconsin: Rock County and the cities of Janesville and Beloit.

In each State, we arranged meetings with personnel in the State health and welfare departments, and in at least one local area. Occasionally some State personnel accompanied us on local visits. The meetings were informal and frequently led into topics which heretofore had not been considered jointly by the health and welfare staffs.

The typical meeting found top representation from administration, medical social work staff from both departments, medical directors or consultants of the welfare departments, supervisors of public health nursing, and, espe-

cially from the welfare department, staff responsible for development of policy and standards. In one area, only two administrators appeared. At the other end of the scale, the chiefs of practically all operating units in both departments met with us.

Open-ended, but directed, questioning was used. Each agency was first asked to describe its overall program, with particular attention to the provision of health services to needy persons. Questions were then directed at relationships in regard to referral of patients, exchange of information, followups, and continuity of service. An attempt was made to call for illustrations of specific problems such as services to tuberculosis patients and to their families; preventive services to mothers and children; the determination of incapacity in aid to dependent children and aid to the permanently and totally disabled and the application of preventive and rehabilitative services once such a determination was made. Case histories often were used to illustrate relationships or the lack thereof, particularly by the local agencies.

This more or less clinical approach was followed by questions designed to bring out interdepartmental relationships arising out of service responsibilities. Since this was generally the most successful method of achieving information, the present report is organized under service titles.

In the preparation of this report, we have drawn upon the meager literature on health and welfare department relationships and also upon the knowledge of agency operations gained in work with such departments.

Patterns of Cooperation

There are many patterns of cooperation between health and welfare agencies which differ in form and degree. Most of them relate to activities somewhat remote from the recipient of service, and few are vigorously directed at the prime goals of health. Moreover, cooperation is practiced relatively seldom and is rarely explicitly defined as policy.

This is not to say that there is noncooperation between health and welfare staffs. There is often simply no relationship on the administrative level. In this connection, Dr. Palmer Dearing, Deputy Surgeon General, Public Health Service, said before the Conference of State Public Welfare Directors in 1950:

"It is conceivable that an effective program might be developed without any formal provisions for cooperation." However, he went on hopefully to say that, "if health and welfare staffs work closely and congenially together and consult spontaneously whenever they deal with interrelated problems, they will inevitably make plans together and define areas of responsibility . . . "(*2*).

Unfortunately, we have found that many health officers specifically avoid the responsibilities arising out of the fact that disease is most prevalent among persons known to welfare agencies. We were told frequently that the health department feared being labeled as an agency for the indigent if it made any special provisions for health services to the needy.

Public welfare departments—dedicated to the prevention of abnormal dependency and to the achievement and maintenance of normal, secure, and productive social living—have the same objectives as public health agencies.

To help clients realize these goals, the welfare department will require professional help in the administration of a medical care program. The definition of medical care is a broad one and includes many of the personal health services which may be provided by or through the health department (*1*).

"Medical care is essential for individual well-being. Its objectives include the promotion of health, the prevention of disease and disability, the cure or mitigation of disease, and the rehabilitation of the patient. Medical care for needy as well as other persons must be geared not only to treatment of disease but also to preventing its occurrence or progress. For those needy persons who are already disabled, all possible use should be made of rehabilitation services so that individuals may be restored to productive living, may cease to require the continued services of other members of the family, and may be enabled to live as useful and happy lives as possible within the limitations of their disabilities."

If preventive services are not known to the welfare program, if they are difficult to obtain, or even refused, then the welfare department will have to establish them. This need has been acute for some time in regard to child welfare

and may soon be as acute in other welfare programs, such as services for the aged.

Welfare departments are acquiring medical administrative machinery, knowledge, and skill. They have long been concerned with long-term illness and disability and with the aged. Services for unmarried mothers, for dependent and foster children, for the aged, and for the prevention of delinquency all involve extended health responsibilities. The alert health officer is interested in all these areas and will help the welfare department find efficient methods of providing the required services. The cooperative efforts of health and welfare agencies will improve the health of the entire community.

Public Health Nursing

Public health nursing services are the most widely used of the health department services available to clients of public welfare agencies. Extensive field relationships between caseworkers and public health nurses, for the most part, appear to revolve around episodes or cases. These relationships are generally informal and unplanned, often the result of an accidental joint visit to a household. In only 1 of 8 States was there evidence of State policy directed at promoting such relationships except in the limited field of institutional inspection. This lack of definition of responsibility generally applies to local agencies as well.

In a number of communities, however, the services of public health nurses have been made available systematically to people served also by the public welfare agency. In Ulster County, N. Y., nurses from the county health department provide bedside care, including injection of medications, as an extension of the teaching program, for welfare clients who are homebound. Staff nurses obtain information concerning the family and home from the welfare caseworker. Case conferences are organized by field workers of the two departments on the initiative of either staff. Informal conferences, apparently more common, also are reported in the regular work sheets.

Some nursing services also are available at local nursing stations and at health department headquarters. The increasing caseload among the aged has increased the bedside care functions of the nurse although the number of patients is not great. Staff representatives of the health and welfare departments have met to consider methods of meeting the need for home nursing service without disrupting the public health nursing program.

The Ulster County public health nurses bring advice on nutrition to welfare families. Nutrition consultation from the State health department thus serves the local welfare agency indirectly. Public health nurses also survey health care of children in foster homes.

This county has a well-developed orientation and inservice training program for staff nurses which draws upon the welfare staff. Much of the teaching is carried out in case conferences which involve all of the community agencies related to the particular case. At the time of our visit, there was no such use of health department personnel in the public welfare agency.

Services for Children

State public health personnel participate actively in both administrative and clinical services for child welfare. Standards for child care facilities and programs of all types are often developed jointly. In several States, the maternal and child health division of the health department provides medical administrative and clinical consultation to the division responsible for child welfare in the welfare agency. In Maryland, a good deal of time has been spent on how, and by whom, health supervision should be provided in foster care and adoption programs. In Wisconsin, requests for consultation have been limited to problem cases, but the board of health participated in establishing the standards for medical care in the foster home program, as well as the standards used by the division for children and youth of the department of public welfare in licensing children's institutions and day care centers.

Locally, the health department is likely to be engaged only in direct clinical services—child health conferences, crippled children's services, and, to a lesser extent, child guidance clinics. Occasionally these services are operated jointly, and the crippled children's services may be under the local welfare department. Relation-

ships are probably developed most extensively in the crippled children's program.

In many States, services for handicapped children engage both State health and welfare agencies, and sometimes, other State and local agencies as well. Primary State responsibility for the State-Federal program is in the health department in 32 States and Territories, in the welfare department in 8 States, and in a combined health and welfare agency in 1 State. In the remaining 11 of the 52 States and Territories reporting in 1954, the program is administered by special commissions (4 States), by departments of education (3 States), and in 4 States by the State medical schools (*4*). Where cooperation is practiced, relationships may extend to case finding, organized referral systems, case conferences, foster home placement, acceptance of responsibility for payment for care, the determination of eligibility, and clinical services.

In California, the State program of crippled children's services is administered by the health department, but in about half of the counties the welfare department has been assigned responsibility by the local board of supervisors. On request, consultation may be provided by either State agency whose field workers maintain an active relationship to determine the best ways of providing consultation.

In Massachusetts, the public assistance and child guardianship divisions of the department of public welfare have agreed to pay the costs of care for their clients when crippled children's service funds are lacking in the department of public health.

In New York State, case finding for the crippled children's program is an accepted responsibility of welfare workers, as well as of health department staff. As long-term custodial care for children who cannot be rehabilitated is difficult to locate, problem cases are discussed by staff members of both agencies. In practice, most of the relationships in New York's program are between the State health department and the local welfare departments. The active support of this relationship by State welfare department policy is important. The welfare departments aid in finding foster homes for handicapped children. For children who are not found eligible for the Medical Rehabilitation Program (the crippled children's service in this State), welfare resources are occasionally called upon to provide services such as certain forms of orthodontic care.

In North Carolina, financial eligibility for care under the crippled children's program of the State board of health is determined by the State board of public welfare. This service, based upon a written agreement, is part of the State's policy of applying a uniform standard of eligibility for health services at State expense. In addition to investigation and certification of eligibility, the State board of public welfare agrees to assist with case finding, to provide transportation for patients to and from clinics and hospitals, to help in locating special equipment and services when crippled children's funds are limited, and to provide casework service to the patient and family in the adjustment to long-term treatment. These services are provided through the county welfare departments under instructions prepared by the State board of public welfare and reviewed by the crippled children's department of the State board of health (*5*). Similar agreements define the responsibilities of the board of public welfare in relation to the cancer program of the State board of health; tuberculosis sanatorium care provided by the North Carolina sanatoriums; correction of defects under the school health program of the board of public instruction.

Tuberculosis Control

The association between tuberculosis and economic deprivation calls for vigorous measures to prevent infection and to treat patients served by welfare agencies. In this area of communicable disease control, interdepartmental cooperation is highest, particularly between local agencies.

In their 1950 reports to the Public Health Service, 11 State welfare departments reported some type of tuberculosis control or hospitalization responsibility (*6*) although major responsibility rested with the State health department. It would be reasonable to expect some kind of relationship between these two State agencies concerning their responsibilities for certain tuberculosis control activities. Nevertheless, the annual report on State tuberculosis

control programs for fiscal years 1954 and 1955 (7) notes as one of the continuing administrative problems "lack of coordination of program activities among all interested State and local agencies."

Cooperation in disease control by State agencies was not evident during our visits. One agency head feared that any notification to welfare clients of the availability of preventive services could be considered coercion and therefore was not an appropriate public assistance activity. A welfare client, he thought, should have the normal opportunity to find out that a chest X-ray survey was due in his neighborhood and any action by the public assistance agency concerning the survey might make the client feel that he had to have an X-ray.

In Wisconsin, however, where the State antituberculosis association and the State board of health cooperate in sending mobile X-ray units around the State, each county welfare department is informed, through the State welfare department, when the unit is coming. All possible channels are used to encourage county agency clients to use the service. The latest tuberculosis control report of the Wisconsin State Board of Health notes that nursing homes are receiving special attention. Oregon also reported special efforts in regard to nursing homes with indigent residents. In this State, representatives of both State boards confer to arrange care for tuberculosis patients.

We found that few local health departments have encouraged the welfare departments to give new clients a chest X-ray. A somewhat larger number of departments, State and local, notify local welfare agencies of chest survey schedules and help them achieve a high level of client participation. A few health departments have conducted campaigns to find tuberculosis among residents of nursing homes, homes for the aged, and lodging houses for single men. Health departments not infrequently provide X-ray facilities, as well as tests for syphilis, for screening possible foster parents or operators of child care facilities. Routine health examinations for personnel of other care facilities, or for health or welfare department staffs are relatively rare.

After diagnosis, coordinated services are needed to help a patient to recover. The patient and his family need to understand the disease and the treatment program. The patient requires knowledge of his family's status and assurance that they will not be neglected. With the patient under hospital care, there

Facilities for Research in Health Related Sciences

The Health Research Facilities Act of 1956, signed by President Eisenhower on July 30, 1956, authorizes the appropriation of funds not to exceed $30 million for each of 3 years to assist in financing the construction of facilities for research in the sciences related to health. The act defines these sciences as including medicine, osteopathy, dentistry, and public health and the fundamental and applied sciences when related thereto.

Assistance will be in the form of grants-in-aid to public and nonprofit institutions. The Federal Government's share is limited to not more than 50 percent. Costs for the acquisition of land or off-site improvements and obligations made prior to the award of the research grant are not creditable for matching purposes.

The Congress has appropriated the first $30 million to the Public Health Service. The funds are to be used, as the act specifies, in providing either or both (1) additional research facilities through the construction and equipping of new buildings or (2) the expansion, remodeling, alteration, and equipping of existing buildings.

A National Advisory Council on Health Research Facilities will establish policies and approve regulations for the administration of the new program. A grant-in-aid must have approval of the council before it can be awarded by the Surgeon General.

The Division of Research Grants, National Institutes of Health, Bethesda 14, Md., will supply application forms and any information requested.

should be periodic reports to and from the community agencies concerned with the patient and his family. Case conferences to set rehabilitation goals and make appropriate predischarge plans smooth the path back to active life. When care on an ambulatory basis becomes possible from a clinical point of view, social, economic, and public health problems which stand in the way of such therapy must be solved by coordinated efforts.

The integrated service of a combined local department of health and welfare, as in San Mateo County, Calif., has pioneered in meeting the needs of patients with tuberculosis. This department is responsible for the county institutions as well as for the full range of public health and public welfare services.

The entire tuberculosis control program is under the medical director of the sanatorium, to assure continuity of service from case finding and diagnosis through followup. A full-time public health nurse at the sanatorium keeps liaison with the field staff. Problems relating to the treatment plan for a patient are usually worked out in the district by frequent and informal meetings between the public health nurses and caseworkers.

If difficulties require administrative consideration, the family is brought to the attention of the supervisors. Medical consultation is immediately at hand. The staff confers on patients under care twice each month. A representative of the social service division participates whether or not the patient receives public assistance.

Planning 2 to 3 months ahead in anticipation of discharge from the sanatorium applies to every public patient in San Mateo County. The sanatorium itself has a rehabilitation program in which a representative of the district office of the State bureau of vocational rehabilitation shares. Psychiatric services also are provided. Thanks in large part to the relationship established by the department in this program, an unusually low proportion of patients leave the sanatorium against medical advice.

Services for Chronically Ill and Disabled

In most communities, unfortunately, relationships in regard to chronic diseases and adult rehabilitation are not strikingly different from relationships in regard to disease control, with a few possible exceptions.

Basic Studies for Program Development

In two States noted for their chronic disease programs, California and New York, departments share actively in basic studies for program development. New York State studies have been concerned with the extent of chronic illness and disability. In California, the director of the State department of social welfare served on the advisory committee for the chronic disease investigation conducted for the legislature in 1949 by the State department of public health. Welfare directors of 38 counties contributed their experience as well. Welfare officials contributed also to the 1954 health survey conducted by the chronic disease service of the State department of public health.

Mutual Support of Legislation

Cooperation on legislation, though somewhat rare, was noted in several States. Development of the Lemuel Shattuck Hospital in Boston, operated by the Massachusetts Department of Public Health, may be credited to the joint planning of the health and welfare departments and to their mutual assistance in preparing and supporting legislation required for its construction. This hospital for persons with chronic diseases is a base for both service and research.

Case Finding

Case finding is not widely practiced in welfare departments except in relation to communicable disease. For example, no State welfare department in 1950 reported to the Public Health Service responsibility for diabetes control(*6*); only 7 State welfare departments reported contributing to heart disease control; only 8 to cancer control. This listing, however, does not cover "unofficial" responsibilities. Massachusetts, for example, is not included although the State health department's 26 tumor clinics regularly refer to the welfare department cancer patients who require and are unable to afford long-term care.

While welfare departments do play a part in case finding for certain communicable diseases, most welfare staffs do not yet have suffi-

cient knowledge to be an effective case-finding instrument for the noncommunicable chronic diseases.

Determination of Disability

Health department clinics in orthopedics, venereal disease, rheumatic fever, chest diseases, and cerebral palsy often help welfare departments determine a client's disability. The general medical services, including clinics, of about 70 local health departments across the country are the major or sole source of medical care for welfare patients in these areas. A few of these departments, such as the Baltimore City Health Department, have attempted to work toward the prevention of disease, especially chronic disease, by offering physical examinations. A few, such as the health department in Newark, N. J., have disability evaluation units. And here and there, a local health officer serves as medical member of the welfare department's review team for eligibility for aid to the disabled.

Rehabilitation

Aggressive concern with rehabilitation is a relatively recent development in welfare work (*8*), encouraged undoubtedly by the newest category of public assistance, aid to the permanently and totally disabled. Accompanying this new interest, however, is a certain feeling of frustration due, no doubt, to many long years of failure to obtain rehabilitation services for public welfare clients. Hence, a few welfare departments have developed their own rehabilitation programs (*9*).

For most departments, this choice is neither wise nor possible. It ignores the resources of the local health department for the development, application, and coordination of rehabilitation services. Certainly the public health staff can help welfare workers concerned with rehabilitation problems by interpreting the social meaning of medical findings and acquainting them with the medical aspects of rehabilitation.

There are a few places, however, where health departments have put their long experience with habilitation and rehabilitation of crippled children to effective use for all age groups. We know of only one State where this is policy: Washington, where every local health officer serves as medical consultant to the district vocational rehabilitation counselor. Weekly meetings serve the day-to-day administrative needs of the vocational rehabilitation program. In addition, monthly conferences include any other local agency with an interest in a case on the agenda. The State health officer feels that this arrangement has been successful.

The California State Department of Public Health has been of help in the development of policies and procedures for improving opportunities for rehabilitation among the disabled parents of recipients of aid to needy children. The detailed story of the several interrelated projects involving the State department of social welfare, the bureau of vocational rehabilitation, and the department of public health is told in a series of publications (*10–14*).

Institutional Standards and Licensure

Probably the best developed cooperative relationships at State level revolve around institutions, particularly their licensing. Information obtained from 44 States in 1953 indicated that in 30 States the health department had legal responsibility for the program for all institutions serving older people (*15*). Six States assigned to the welfare department the accrediting program for all such institutions. And in eight States, responsibility was assigned to the health or welfare department according to the nature of the institution. The 1950 State health department reports to the Public Health Service indicate that, while health departments have major responsibility for licensing medical institutions in most of the States, welfare departments are responsible for most child care facilities in the States where there are licensing provisions; and in a few States, the welfare agency is responsible for the general or special hospital facilities (*16*).

Expert guidance, consultation, and field service from personnel skilled in health and social services are required if programs of licensure or other forms of accreditation are to be more than perfunctory. Both health and welfare agencies know that licensing can be a "tool" to achieve a higher level of care and service. General health care, rehabilitation, the prevention of

secondary disability, accident prevention, the use of nursing, nutrition, and social services, all call for their joint attention.

Cooperative efforts range from contractual agreements to informal but regular visits by field personnel of the licensing agency to the local health or welfare office for exchange of information. Joint action may include:

- Definition and approval of standards.
- Assignment of responsibility for various aspects of the inspection and licensing program.
- Development of an educational program for the participating agencies, their local opposite numbers, and for the operators of facilities.
- Exchange of information relating to the licensed facilities.
- Coordinated efforts, when necessary, for enforcement of the licensing law and regulations.

These activities may be based on law or they may grow out of contractual agreements. In some places, the policy of each agency specifies working with other agencies to meet the responsibilities assigned by law or custom to one or the other agency. Most commonly, however, these joint activities, as do so many others, rest on the authority of custom.

One of the successful statutory requirements for sharing responsibility in an institutional licensing program is found in Kansas. "Adult boarding homes," which include proprietary skilled nursing, personal care, and simple shelter facilities, are licensed by the State department of social welfare. The law calls for the participation of the State board of health and the State fire marshal as well as county health and welfare departments and the local fire and safety authorities. Child care facilities are licensed by the State board of health in conjunction with State and local agencies indicated above. In each area, teams jointly inspect the homes. Their visits are supplemented by calls by individual team members to help the home administrator.

In Sedgwick County, interdepartmental meetings have grown out of the licensing program. At these meetings, boarding home management and care of their residents, and child welfare and child care facilities are discussed.

Even in this apparently well-planned development, however, a recent study of the attitudes of public health nurses in the adult boarding home program reveals complaints of overlapping responsibilities, difficulties with representatives of other agencies, slights to professional prestige, and administrative failure to heed their professional judgments. Nevertheless, this joint program has improved and increased agency services to recipients of public assistance and has certainly increased the quantity of preventive health services made directly available to these recipients (*17*, *18*).

In California, a tripartite agreement on standards and licensure responsibilities is observed by the State departments of public health, social welfare, and mental hygiene in regard to sheltered care for older people. The agreement results from a policy of working together to define the tasks that arise from responsibilities assigned by law to one or another department; to outline the knowledge, technical skills, and contacts of each department which could help the assigned agency to meet its obligation; and to agree on the use of all of the appropriate resources. Actually, joint conferences in this State preceded the writing of the law, to assist the legislature in preparing the requisite legislation. Such conferences are a regular feature of interagency relations in the California State Government. Mutual support of legislative programs and budget requests, based on understanding and an appreciation of common interests, is a natural outgrowth of this policy.

Oregon also offers interesting examples of interdepartmental institutional services. The State board of health licenses nursing homes and periodically circulates a list of licensed homes to the State and local welfare departments, a service that is by no means common, however elementary. The field staff of the licensing division visits the county welfare offices to learn what the staff knows about care in local nursing homes. This productive relationship, although found in a number of States, is often overlooked even in States with well-developed relationships in other areas.

The criteria for rates of payment to nursing homes were developed by the Oregon Public Welfare Commission with board of health con-

sultation to relate payments to services needed and received.

Day care centers for children, a responsibility of the Oregon Public Welfare Commission, must have standards certified by the board of health to be eligible for monthly State aid. Group care homes for mentally and physically handicapped youngsters, licensed by the board of health, must meet standards set in part by the public welfare commission.

In Maryland, an interdepartmental committee sets criteria for rates of payment by the welfare department for nursing home care. A similar joint committee, with representation from health, welfare, and education develops standards for the licensure of day care centers in Maryland.

In Massachusetts, day care facilities for children, licensed by local health departments, use standards developed by a joint committee of the State departments of public health, public welfare, mental health, and education. Consultants of these departments are available to the local areas on request through the district offices of the State department of public health.

Illinois provides another "example of the way in which the health and welfare departments can work together to improve the service provided." The State department of public health, the licensing agency, sends to the public assistance agency copies of all letters to individuals operating or planning to establish nursing homes. This enables the State public assistance agency to exchange information with county welfare departments concerning nursing homes which have been or are about to be licensed.

Nine Grants for Hospital Research

Nine grants totaling $367,182 for new research and demonstrations in hospital service and administration were announced in July by the Public Health Service of the Department of Health, Education, and Welfare.

The research is aimed toward improving the care of patients in hospitals and health facilities, reducing costs, and helping to make the benefits of hospital and health services more widely available.

The University of North Carolina School of Medicine, Chapel Hill, will study the referral of patients from rural areas to the outpatient clinic of the university hospital.

The University of Tennessee College of Medicine, Memphis, will demonstrate how a coordinated hospital plan for the entire State can be developed.

The University of Michigan, Ann Arbor, will initiate two projects: (1) A study of how the organization, staffing, and procedures in 20 Michigan hospitals are related to the type of care the patients need and receive, and (2) a study of the relationship of administrative and supervisory practices in hospitals, motivations and job satisfaction of the employees, and effectiveness of job performance and organization.

St. Louis University, St. Louis, Mo., will develop a program of graduate study in hospital administration at the doctorate level for advanced students to carry on research.

Columbia University School of Public Health and Administrative Medicine, New York City, will study the influence of different patterns of organizational and community relationships and of new hospital construction on the quality of medical, hospital, and related health services.

The Council of Jewish Federations and Welfare Funds, New York City, will study the coordination of the facilities of the general hospital with the resources of other medical and related community services.

The Minnesota Department of Health, Minneapolis, will initiate a project to demonstrate how the quality of service given patients in State hospitals can be improved through the development of methods for inservice training.

The American College of Physicians, Philadelphia, will study methods for minimum standards of quality and efficiency for evaluating the practice of internal medicine in hospitals.

Observations of the public assistance visitor and of physicians who treat public assistance clients are transmitted to the health department. The two State agencies have cooperated, when indicated, in revoking or refusing a license. This close cooperative arrangement has helped to improve the quality of care in the commercial and other nursing homes in the State (*19a*).

Local departments of health usually have limited relationships with State institutional licensing programs whether they be administered by the State health, welfare, or other agency. The local department may serve as a source for a sanitarian. On the other hand, county welfare departments are often prime sources of information on nursing homes and similar facilities, even when the State licensing program is administered by the health department. Unfortunately, there is rarely a two-way flow of information to enable the local agencies to know what recommendations have been made to institutions, what disciplinary action is pending, or which facilities are currently approved.

New York provides a notable exception to this generalization. Here the State department of social welfare administers the "approval" program for nursing homes and in addition some county health departments license these institutions. To help maintain the positive direction of these parallel accrediting programs, a working agreement has been developed between the respective authorities.

The report of a recent APHA study of the chronic disease activities of selected local health departments states that 72 departments (of 187 selected for study) license institutions caring for persons with long-term illness or disability. Seventy-one said that they participated with other community agencies in establishing standards of care in these institutions. Few indicated a solitary role in standard-setting. The report will be presented at the annual meeting of the American Public Health Association in November 1956.

Nutrition Consultation

Nutrition consultation is a popular and useful institutional service which crosses departmental lines (*20*). The APHA study reported that, of the departments selected, 70 offer such consultation to institutions caring for the chronically ill and disabled. Forty of these departments employ a professional nutritionist; the others presumably draw upon a State consultant or upon their public health nursing staff.

The Nassau County (New York) Health Department has a unique feature of teaching nutrition in a program directed generally at improvement of service in nursing homes. A local licensure provision assigns to the department responsibility for setting standards and licensing nursing homes. The consultant services of a nutritionist from the State department of public health are available to the local department and there has been some direct service to nursing homes from the State health department personnel. Medical consultation relating to diet is available within the county department. Results of the Nassau County program with respect to food practices, safety, and nursing care confirm the usefulness of this educational approach (*21*).

The Illinois Department of Public Health also maintains a nutrition consultation service in its licensing program (*22*). In Maryland and Wisconsin, nutrition consultation is offered not to institutions but to the welfare department staff concerned with standards and licensure for children's institutions.

Payment for Institutional Services

Although public agencies have a growing responsibility for payment for institutional services, no one of the agencies is likely to have a staff adequate to ascertain that the public monies are well spent for institutional care. In many States, each agency purchases such services separately, with resulting annoyances and inequities to the institutions, and duplication of effort. It is an unfortunately common practice to pay higher rates for the care of bed patients than for patients who get out of bed with or without aid. (We do not recommend decreases in such payments. Rather, in view of the generally low and unrealistic rates of payment to nursing homes, we would call for the eventual application of the principle of payments based on the costs of care.)

There are several examples of cooperative action relating to the rates of payment to hospitals and related facilities, such as the joint committees for nursing homes in Oregon and Maryland mentioned above. Rates paid by the New Hampshire Department of Public Welfare also are based on a classification of nursing homes by the State board of health.

In two States, interdepartmental committees representing the major purchasers of general hospital care have agreed upon methods of establishing hospital payment rates. In Illinois, such a committee has operated successfully for the past 11 years (*19b*). There the State department of public health, the public aid commission, the division of services for crippled children of the University of Illinois, and the State division of vocational rehabilitation use the same Technical Advisory Committee on the Purchase of Hospital Care. Members are hospital administrators representing the Illinois Hospital Association who meet periodically with representatives of the four participating agencies to advise on a cost formula and payment agreements. The State department of public health provides staff, collects and analyzes the cost reports, certifies the cost figures, and classifies the hospitals. Each agency then agrees to pay hospitals on the basis of the certified costs.

In New York State, a similar plan is coordinated by a Hospital Rate Advisory Committee with representatives from health, welfare, education, mental hygiene, and the executive departments. The bureau of research and statistics of the department of social welfare makes the necessary statistical computations and certifies rates to each agency.

Rates paid to hospitals in Massachusetts by the department of public welfare are based on a formula and procedures for cost analysis worked out by the department of health and the State hospital association. In Virginia, the State department of health reviews and certifies hospital cost analysis for the department of welfare and institutions and the division of vocational rehabilitation and advises on hospital administration and licensure.

Interdepartmental services related to institutions appear to demonstrate the only clear-cut and consistent collaborative use of the skills of State health and welfare departments. But their potential for improvement of institutional services to people has barely been tested. Nor have they been used sufficiently to bring the resources of the two agencies together to consider other areas of mutual concern.

Consultation Outside Institutions

Consultation services are by no means restricted to the institutional setting. In the APHA study already mentioned, 123 local health departments (of 187 respondents) said that they provide consultation to the local welfare department. And 125 departments indicated that they receive consultative services from the welfare department. Only 34 health departments of 187 with some kind of active chronic disease program employ their own social workers. But another 123 departments use social work services obtained through some other agencies.

Asked whether the health department had knowledge of the welfare department policy on food expenditures, four health departments said that the information was not available from the local welfare department. Forty-one of the 187 health departments did not have the information.

In Quincy, Mass., on the other hand, the health department nutritionist has been an active participant in public welfare programs, assisting in training caseworkers and consulting on special diets. She has visited with caseworkers at homes where large families with small budgets need advice on food selection.

The bureau of nutrition of the New York State Department of Health, in addition to providing consultation to the State department of social welfare, has helped to bring together local public health nurses and caseworkers for education on food budgeting and nutrition. State nutritionists have also served as consultants to local interagency conferences of public health nurses, caseworkers, and casework supervisors concerned with specific families and their diet.

General Administrative Services

The California rehabilitation project mentioned earlier (*14*) was designed not only to

extend the use of rehabilitation services but also to demonstrate the advantages of regular medical consultation to the public welfare program, and to call the attention of local departments to one of the ways of obtaining consultant services. A contractual agreement between the State departments of public health and social welfare calls for the full-time assignment of a medical officer to the welfare department.

New York State also offers examples of effective sharing of professional personnel. A health department nutrition consultant prepared a special diet manual for the department of social welfare and is available for other services. A dental consultant is detailed from the health department to provide services on a part-time basis. And, in an instance that is still unique, a deputy commissioner of health has been assigned to the department of social welfare full time as director of medical care. He has ready access to the resources of both departments, attends staff meetings of both organizations, and acts as interpreter of the programs of both agencies. The background of public health administration has made itself manifest in the medical care program for the needy, notably in rehabilitation services, in nursing home care, and in physicians' services.

The State department of social welfare has vigorously supported requests of the health department for social work staff. It has helped to draw up standards for such staff and has invited health department medical social workers to participate in semiannual meetings of its own medical social workers. The medical social service chief has provided orientation sessions on the welfare program to the public health nurses of the department of public health.

Many State agencies fail to provide staff orientation in programs of related agencies, not to mention their own. Everyone appears to agree on the need for such orientation and most ruefully admit there has not been time to carry out adequate orientation in their own program.

Among devices for achieving knowledge of programs of other agencies is the joint committee, such as the New York State Interdepartmental Health Resources Board with representatives from the departments of education, health, mental hygiene, correction, labor, and social welfare; the Workmen's Compensation Board; and the Joint Hospital Survey and Planning Commission. Committees of the board provide a machinery for joint planning, coordination, and consultation. Other interdepartmental bodies, not part of the State interdepartmental health council but with health and welfare participation, include advisory committees to the department of mental hygiene and to the State Youth Commission.

None of these bodies is simply a paper representation. All have been concerned with planning and consultation and with joint studies and legislation. The State plan for chronic disease and rehabilitation facilities was thus jointly developed, as was also the rehabilitation program for adult public assistance recipients at the rehabilitation hospital operated by the State health department.

Local services and activities affecting administration of both health and welfare departments have been mentioned above under program titles, such as the use of joint staff conferences concerning patients with tuberculosis, child care, or for the definition of rehabilitation objectives for a patient. Such conferences for the solution of clinical problems play an important part in administration per se. They are, in themselves, manifestations of administrative policy. Case conferences serve also to bring people and agencies together, to understand one another and to exchange ideas and information. Often, the conference results in the definition or clarification of broad policy.

A meeting of the Suffolk County (New York) Health and Welfare Department staffs, about 2 years ago, showed how multiple demonstration case conferences in a workshop setting help achieve "more efficient interagency referral and communication systems" (*23*) and more direct contact among staff members. As a result, a joint committee was formed to interpret each agency's progress "and to develop further techniques for a better understanding of each agency's program," with consequent increase and improvement in referrals to both agencies.

Joint committees and active membership in community councils of social agencies are familiar methods of approaching common problems. They may be used also as the setting for

joint planning. Joint committees on nutrition, aging, adoptions, mental health, rehabilitation, and nursing homes are among the usual ones. Council committees on housing, on determination of medical indigency, and on medical care for the needy are not uncommon in communities engaged in evaluation of health and welfare services.

In addition to their technical consultation services, health department representatives may serve on the advisory committees of the public welfare program and on the board itself to encourage a preventive approach in both health and welfare programs.

Comparison of State and Local Relationships

Relationships between State health and welfare departments, whether established by law, contract, or verbal agreement, are more likely to be in the administrative area than in the area of direct service.

In local departments, direct service produces the greatest evidence of joint effort although, for the most part, cooperation is personal rather than official. This relationship could be broadened and made more effective by formal State and local policy.

Conclusion

Five years ago, former Surgeon General Leonard Scheele (*3*), speaking to the American Public Welfare Association, said:

> At any gathering of health or welfare people, the need for a cooperative attack upon interrelated problems is likely to be discussed. Public health people talked about it extensively at the recent American Public Health Association meetings in St. Louis. There is an equal eagerness among social workers. Yet, after the meetings are over, a cold, analytical look at actual operations in local communities and throughout the Nation shows that the "trend" toward cooperation is painfully slow. From the standpoint of structure for cooperative action, these organizations seem to be almost as far apart as they were in the days when welfare meant an occasional coal or grocery order and when public health meant a red placard on the home of a scarlet fever patient.

Although our current report describes patterns of cooperation among our State health and welfare agencies, Dr. Scheele's statement of 5 years ago still applies. It is our impression that we have yet to reach the following four goals of joint activity:

1. Application of the normal program of the health department to the welfare population through active cooperation with welfare departments.

It may be necessary to modify or extend services within the range of knowledge, skills, and budget of the health department in order to meet the health needs of the welfare population. Meeting these needs may, of course, result in establishing an effective program of disease prevention.

Since ill health and disability rank so high among the causes of dependency, there is a moral responsibility and, in many instances, a legal responsibility to make health services available to the population in need.

The role of the welfare department in achieving the full application of the program of the health department to the welfare population requires active encouragement of welfare clients to use health services, especially preventive services. Welfare agencies do not hesitate to offer advice on a family budget or the food content of the diet possible within that budget. The relationship between client and agency offers an equally good opportunity for advice on when and how to use health services.

2. The development of appropriate health promotion and disease prevention activities in the welfare program itself.

A major responsibility of the health officer and his staff is to aid the welfare staff in identifying and developing areas in the welfare program which can serve to promote, protect, and restore the health and social usefulness of the people who come to the department for help.

First and probably most important is intake. Intake offers the ideal opportunity to determine the health status and needs of the potential client. This is the chance, usually neglected, to make preventive health services available as well as to establish a medical plan for the person and family in need.

Once the welfare department has accepted the client for service, the avenues toward health services are many and the guide is usually the caseworker. The achievement of health by the

client, therefore, depends in large part upon the caseworker's alertness to the client's health needs and the worker's knowledge of the community's health resources. The welfare department needs the help of the health department in providing the orientation and knowledge necessary to create a high level of health interest among its staff. In our experience, welfare departments rarely call upon their health colleagues for such help.

Surely it is important for the caseworker who enters the client's home to be alert to the health status of the entire household; to try to ascertain what hazards to health arise out of the physical environment of the home and out of the social dynamics of the life within it. The translation of this knowledge into constructive family action implies health education, for which trained personnel of the health department should be able to offer knowledge, skills, and materials, as well as assistance through staff development programs in the welfare department.

In each of the categories of public assistance administered through the local welfare agency, there are opportunities for health department participation in identification of needs, in planning, in consultation, in the provision or coordination of services. Identifying and planning to meet rehabilitation needs of parents of recipients of aid to dependent children, tuberculosis screening for recipients of old age assistance, and consultation on problems among recipients of aid to the permanently and totally disabled are examples of services now provided in a few places by State and local public health departments.

As to general medical care, every welfare agency has one or more opportunities to tell its clients about services available and to encourage their intelligent use. There should also be opportunities to define the objectives of the medical care program to the providers of service and to assure that the program can function so as to achieve its objectives.

A positive approach to medical care, as distinguished from preoccupation with disease treatment, will emphasize prevention, early diagnosis, prompt treatment, and active rehabilitation. Such an approach will encourage appropriate use of the physician's services rather than impress upon the client that "he must not seek the doctor's help unless he absolutely needs it." Health department representatives, serving among other members of a medical advisory committee, can help to develop and foster a positive approach to the medical care program.

In some instances, the health department's personnel and services may be all, or part, of the medical care program. Unfortunately, we have found that even when the health department is responsible for the general medical care program, a positive approach does not automatically ensue.

The current emphasis on extension of welfare department services beyond cash assistance implies a continuing increase in the health responsibilities of welfare agencies: services for unmarried mothers, for dependent and foster children, for the aged, and, in some communities, for families at large; and services directed at prevention of juvenile delinquency, control of alcoholism, or at the maintenance and improvement of standards of institutional care. In defining the objectives of these programs and in developing ways to attain their goals, welfare and health departments need to pool their knowledge. This is reason enough for getting together.

3. An increased awareness of the social and economic needs of persons coming to the attention of the health department and a clear understanding of the responsibilities, the potential activities, and the limitations of both agencies in support of people with such needs.

The welfare department has a right to expect that the health department is prepared to make referrals appropriate in content and time. Conversely, the health department has the right to expect appropriate referral for the services it offers. But this right is not fulfilled automatically. Public health nurses may have a hard time relinquishing part of their responsibility for patients, as caseworkers may for their clients. Successful referral programs provide administrative support and assurance through knowledge of personnel and operations, that the best interests of their patients or clients will be served by referral. Regular contact between the agencies concerned is needed to make this possible.

4. The development of the necessary policy and procedures to achieve improved health and welfare services without duplication when several agencies are involved.

Many functions of welfare departments touch those of the health department. And "touch" is often about as far as the relationship goes. This is true particularly when institutional inspection and licensure are assigned the welfare department and the health department is assigned responsibility for the sanitation inspection. This latter function rarely extends beyond the determination of technical compliance with the law and its regulations. The standards of nursing home care appear to have been markedly improved, however, in those States and counties where health and welfare department cooperation has been consciously organized. Crippled children's services, the tuberculosis control program, and rehabilitation services for adults likewise are improved where there are mutual responsibilities.

Examples of cooperative activities directed toward this goal range from organized referral procedures and a policy of using interagency case conferences to written contracts for the provision of specified services under stated conditions and to mutual study of long-range needs and support of legislation.

When these objectives of joint activity are reached, efficient operation will be assured, and the potential for better service, where responsibility overlaps, will be recognized. Each agency will be sensitive to the needs, and aware of the resources, lying outside of its own area of service.

To date, in the words of former Surgeon General Parran (*24*) : ". . . In the tremendous problem of providing [health services] for the indigent, the social welfare agencies have taken the lead, largely because health departments have been unwilling or unable to accept this as a direct responsibility. The situation, however, is somewhat analogous to the relation of the health officer to the public water supply. He must know the needs for an adequate supply of potable water. He champions the provision of such a supply. He sees to it that the water plant is properly operated, even though this may be done by another branch of the city government. This is the minimum responsibility which the health department should assume, both for the public water supply and for the public medical service needed by those unable otherwise to provide it. In fact, the health department should be instigator of and friend to all useful activities for the conservation of life and health. For if health officers do not recognize their responsibility, using all the methods given us by science, to organize community attacks upon the causes of ill health, the public health profession will revert to the ancient status of sanitary police, and other public medical agencies will be established to deal with the major health problems of today and tomorrow. We may be sure such problems will be dealt with."

REFERENCES

(*1*) Tax-supported medical care for the needy. Am. J. Pub. Health 42: 1310–1327, October 1952.

(*2*) Dearing, W. P.: Medical care for public assistance recipients. Pub. Health Rep. 66: 89–97, Jan. 26, 1951.

(*3*) Scheele, L. A.: Cooperation between health and welfare agencies: A health officer's view. Pub. Health Rep. 66: 163–166, Feb. 9, 1951.

(*4*) U. S. Department of Health, Education, and Welfare: Annual report, 1954. Washington, D. C., U. S. Government Printing Office, 1955, p. 66.

(*5*) Statement of understanding between North Carolina State Board of Public Welfare and the Crippled Children's Department of North Carolina State Board of Health, Sept. 9, 1947. Raleigh, N. C., 1947.

(*6*) Christensen, A. W., Flook, E., and Druzina, G. B.: Distribution of health services in the structure of State government, 1950. Part 3. Personal health services provided by State government. Public Health Service Pub. No. 184, part 3. Washington, D. C., U. S. Government Printing Office, 1953, pp. 131–146; 159–171.

(*7*) U. S. Public Health Service: State tuberculosis control programs as planned for fiscal years 1954 & 1955. Public Health Service Pub. No. 396. Washington, D. C., U. S. Government Printing Office, 1954.

(*8*) American Public Welfare Association: The place of rehabilitation in the public welfare program—a statement of policy. Public Welfare 13: 47–84, April 1955.

(*9*) Muller, J. N.: The rehabilitation program of the department of welfare, City of Chicago. Public Welfare 13: 3–7, January 1955.

(*10*) Lefson, L.: Rehabilitating public assistance recipients. Public Welfare 11: 47–50, April 1953.

(11) Lefson, L.: From public assistance to gainful employment. Performance 3: 4–5ff., April 1953.
(12) California State Department of Public Welfare: A medical study of incapacitated fathers receiving aid to needy children. Sacramento, March 1954. Processed.
(13) California State Department of Education: Rehabilitation of disabled parents in the aid to needy children program. Bull. California State Dept. of Education 23, August 1954.
(14) Freedman, D. K.: Medical consultation in the State department of social welfare. California's Health 12: 113–115, Feb. 1, 1955.
(15) Standards of care for older people in institutions. Sec. 2, pp. 77–112, New York, National Social Welfare Assembly, National Committee on Aging, 1953.
(16) Mountin, J. W., and Flook, E.: Guide to health organization in the United States. Public Health Service Pub. No. 196. Washington, D. C., U. S. Government Printing Office, 1952, p. 52.
(17) Foote, R. E.: The public health nurse in the adult boarding home program. A talk delivered to the public health nursing section, American Public Health Association, Nov. 15, 1955. Topeka, Kans., Kansas State Board of Health, 1955. Processed.
(18) Tracy, L. E.: How public health nurses feel about the adult boarding home program. A report delivered to the public health nursing section, American Public Health Association, Nov. 15, 1955. Topeka, Kans., Kansas State Board of Health, 1955. Processed.
(19) Bierman, P.: Role of the State public assistance agency in medical care. A series of reports. (*a*) VII. Nursing home care; (*b*) V. Hospital care. Chicago, American Public Welfare Association, 1955; 1954.
(20) Nutrition services—a summary report of a study of public health nutritionist services to child care institutions and foster family homes. Children 2: 236, November–December 1955.
(21) Kinnaman, J. H., et al.: Attending the nutritional needs of patients in nursing homes—Theory and practice. Am. J. Pub. Health 45: 627–631, May 1955.
(22) Ranck, M., and Cunningham, R. R.: The health department and nursing homes. Pub. Health Rep. 67: 829–834, September 1952.
(23) Suffolk County sees need for interagency contact. New York State Dept. Health Bull. 7: 127, Jan. 3, 1955.
(24) Parran, T.: Reporting progress. Presidential address to the American Public Health Association. Am. J. Pub. Health 26: 1071–1076, November 1936.

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